Little Hoover Commission Testimony
Children and Mental Illness
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John Landsverk, Ph.D.
Child and Adolescent Services Research Center
Children's Hospital – San Diego
and
School of Social Work
San Diego State University

Introduction

Thank you for inviting me to testify about the need for mental health services and access to services for children and adolescents in California. I am pleased to do so. My introductory remarks will extend the testimony provided by Dr. Rosenblatt in an area of special concern for mental health care, namely, care for youth in the child welfare and juvenile justice systems.

Child welfare and juvenile justice are not formally a part of the mental health service system. Child welfare is focused on protection of children, primarily in the context of child maltreatment, while juvenile justice is focused on addressing the issue of status offences for youth in our country. That said, it is important to note that both child welfare and juvenile justice provide services to children and adolescents who are at very high risk to develop serious mental health problems.

This presentation will focus on the special issues involved with identifying mental health care need and providing mental health services in these two sectors of care. Most of the information that I will provide in testimony will come from studies of child welfare, especially foster care, since this is where most of the research has been conducted. However, studies have also begun to document the high risk of children in child welfare for later turning up in the juvenile justice sector. It is highly likely that youth in both sectors are likely to come from very similar pools of youth and share many risk factors – and that entry into the child welfare sector usually precedes entry into the juvenile justice sector.

Research studies over the past two decades have firmly established what practitioners have known for considerably longer, namely, that children in foster care represent a high risk population for maladaptive outcomes, including socio-emotional, behavioral, and psychiatric problems warranting mental health treatments. The major risk factors for maladaptive outcomes include the maltreatment experiences that lead to foster care placement and the stress of removal from home.

Need for Mental Health Services

Most studies of children living in foster care have shown that they exhibit problems requiring mental health assessment and/or intervention at a considerably higher rate than what would be

expected from either normative data or from community studies. There is also some suggestion that externalizing disorders in particular may be more prevalent than internalizing in the foster care population.

As an example, Trupin and colleagues in the state of Washington compared children receiving protective services from child welfare with a criterion group of children in the state's most intensive mental health treatment programs and found that 72% of the children in child welfare exhibited profiles of severe emotional disturbance indistinguishable from the criterion group

Five of the nine recent studies were conducted with children entering foster care in California. Researchers in Sacramento conducted a comprehensive screening and evaluation of 167 children between the ages of one and ten who were made dependents of the juvenile court in Sacramento for reasons of child abuse and neglect. They found that 68% of the children displayed significant problems in one of four psychosocial domains.

In studies conducted over the past decade in San Diego County, my colleagues and I have determined for children between the ages of four and sixteen that 43.2% in the kinship group and 51.9% in the non-relative foster care group were in the problematic range on total behavior problems. In a more recent study of children six years and older who were in either the child welfare or juvenile justice populations, we have found that over 40% of the 426 child welfare youth and over 50% of the 478 juvenile justice youth met criteria for one or more DSM IV psychiatric diagnoses with a moderate level of impairment.

In addition there is clear evidence that between 50% and 65% of children entering foster care up to the age of six show significant problems in developmental functioning.

In summary, the research literature based on studies across several states suggests that between one-half and two-thirds of the children entering foster care or juvenile justice exhibit emotional and behavior problems warranting mental health services. The rate of problems is significantly higher than what would be expected in community populations. Furthermore, these maladaptive outcomes range across a number of domains, rather than being concentrated in only broad behavior problems.

Use of Mental Health Services

In contrast to the psychosocial functioning of children in foster care, fewer studies have examined the use of mental health services for these special populations. Several studies have examined use of services by children in foster care. No studies have yet reported out use of services by the juvenile justice population.

Two studies of mental health service use by children in foster care have used Medicaid program claims data, one in the state of California and one in the State of Washington. The Medicaid data from these two states are especially relevant because Washington and California both have made all children in foster care categorically eligible for the Medicaid program regardless of the eligibility status of their biological parents. In California rates of health care utilization and associated costs were compared between the 50,634 children identified in foster care and the 1,291,814 total program eligible children. While the children in foster care represented less than

4% of the population of Medi-Cal eligible users, they represented 41% of the users of reimbursed mental health services and incurred 43% of all mental health expenditures. This over-representation among mental health service users held for all age groups within the foster care population, ranging from rates of 31% for children under the age of 6 and 32% for children between the ages of 6 and 11 to 49% for all users between the ages of 12 and 17. The investigators further determined that children in foster care had an age-adjusted rate of mental health service utilization which was 15 times the overall Medi-Cal population that served as the reference group. The investigators found that this pattern of greater utilization was also true across many different types of mental health services, with children in foster care accounting for 53% of all psychologist visits, 47% of psychiatry visits, 43% of public hospital inpatient hospitalizations, and 27% of all psychiatric inpatient hospitalizations.

Comparable findings have been reported for Washington State.

Our San Diego County studies have examined use of mental health services in a cohort of 662 children between the ages of 2 and 17 (approximately five months to eight months after entry into foster care) and found that 50% of the children had used mental health services within the period between entry into foster care and the first interview. The proportion using mental health services ranged from 21% of the children ages 2 to 3, 41% of the children ages 4 to 5, 61% of the children ages 6 to 7, and over 70% for children and adolescents over the age of 7. These rates contrast sharply with the less than 10% of the same foster children for whom there was evidence of mental health care utilization prior to entry into out-of-home placement.

In summary, two California studies and a state of Washington study demonstrate a very high rate of use of mental health services across all age groups, with the highest rate of 70% shown in children over the age of seven. The studies using Medicaid data confirmed this much higher rate for children in foster care in contrast to the much lower rates seen in AFDC children.

We believe that the high rate of mental health service use observed for children in foster care is caused by a stronger link between child welfare and mental health systems. In California, there is consistent evidence that the foster care system may serve as a large gateway into the mental health service system for children who have been abused or neglected. Since these two systems share many child and adolescent clients, more explicit collaborative ties need to be forged, directed at improving the efficiency of service delivery.

It would appear that the Medicaid program, as categorically applied to children in foster care, provides a powerful impetus to the provision of mental health services to this specialized population. Medicaid is currently undergoing a major transition to a managed care form of service delivery. We do not know how this shift in the organization and financing of mental health care will affect the mental health treatment of children in foster care. The policy implication is that leaders of the child welfare system and foster care systems need to be pro-active in developing of managed care contracting within the Medicaid program in collaboration with the managers of public mental health systems.

It also appears to be true that the widespread use of mental health services for this specialized population is not accompanied by systematic monitoring of service outcomes for the foster children who are receiving these services. No studies have been published to date that examined

either the quality of care being provided through mental health services or the outcomes of those services. We do not know whether the services are effective in ameliorating the mental health and developmental problems observed in children entering the foster care system. There is a clear need for efficient monitoring of developmental, behavioral, social and adaptive functioning for children in foster care who are receiving mental health services. In short, systems of accountability need to be developed in order to determine the course of treatment at the level of the individual foster child.

Pathways into Mental Health Services

Finally, there is considerable evidence that both clinical and non-clinical factors impact the use of mental health services. Our foster care studies in San Diego County have found that a high level of behavior problems is associated with entry into mental health care. We have also found that sexually abused children are two-and-a-half times more likely to receive mental health services and neglected children are half as likely to receive mental health services even after behavior problems are accounted for. In addition, we have seen that minority children are significantly less likely to received services as non-minority children, even in foster care where economic barriers are very low due to equal access to Medicaid funding.

There is a practice need for the development of explicit guidelines to be used in systematically linking children who show need with clinically effective and appropriate services. In particular, these guidelines need to address the issue of non-clinical factors affecting service use in terms such as access to services, acceptability of services, and perception of need for services by "gatekeepers." The guidelines also need to address the type and severity of maladaptive behaviors warranting referral for mental health services. Eventually, models need to be developed that both recommend specific treatment services based on specific emotional and behavioral problems and allow for some flexibility and creativity in treatment choices for children in foster care.

Finally, there is a need to develop models for family participation in mental health treatment for children in foster care within the context of dual families. Both biological families in the process of negotiating with child protective services regarding the issues of risk for maltreatment, family functioning, and reunification and foster care/ kinship families who are standing in for the biological parent need to be included in models of family participation. This will be necessary so that the policy impetus of family preservation and family empowerment will both be better served while children are receiving mental health services to ameliorate their emotional, behavioral, and social problems.

Concluding Comments and Recommendations

I would like to thank the Little Hoover Commission for this opportunity to provide this testimony. I hope my testimony provides evidence that large numbers of children involved with the child welfare and juvenile justice sectors are at high risk for mental disorders and we need to focus special attention on linking youth in these sectors to the best models of care in the mental health system of care.